

June 1, 2003

# Montana Medicaid Notice

**Inpatient Hospitals, Outpatient Hospitals, Physicians, Mid-Level Practitioners, Ambulatory Surgical Centers, Indian Health Services, IDTFs, Lab & X-Ray, Podiatrists, and Psychiatrists**

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## Discontinued Services

Effective July 1, 2003, Montana Medicaid will implement numerous service changes. These changes include service that will no longer be covered/reimbursable and service that now need to be prior authorized.

The services that will no longer be covered effective July 1, 2003 are:

1. Dermabrasion - removal of surface layer of skin to correct acne scarring and wrinkling (15780-15789)
2. Rhytidectomy - removal of forehead, neck and facial wrinkle (15824-15829)
3. Liposuction of head, neck, trunk and extremities (15876-15879)
4. Correction of inverted nipples (19355)
5. Plastic surgery on penis to correct angulation (54360)
6. Hysterosalpingography- diagnostic test for infertility (58345)
7. Salpingostomy- infertility treatment (58770)
8. Radial keratotomy - this procedure is no longer performed, an updated procedure now exists (65771)
9. Keratomileusis - otherwise known as LASIK eye surgery (65760)
10. Insertion of a penile prosthesis (54400)
11. Construction of vagina (57291-57292)
12. Nocturnal penile tumescence and/or rigidity test (54250)
13. Otoplasty - correction of protruding ear or ears (69300)

## Services That Require Prior Authorization

The services that will start requiring prior authorization effective July 1, 2003 are:

1. ***Blepharoplasty (15820-15823, 67900-67924).*** Surgery of eyelid to improve function, reconstruct deformity or enhance appearance. Medicaid will authorize this service when the eyelid

causes a visual impairment, is a result of trauma, to relieve pain, or other medically necessary situations.

2. ***Botox treatment (J0585, J0587).*** This is a purified toxin that has multiple uses. The Medicaid program will cover Food & Drug Administration approved methods that are medically necessary. At this point in time, FDA approved and medically necessary is deemed to be conditions such as blepharospasm, strabismus and cervical dystonia.
3. ***Excising Excessive Skin (15831-15839).*** This procedure is determined to be medically necessary only when an individual experiences recurring skin infections that are unresponsive to conservative management, interfere with ambulation or hygiene, or cause back pain.
4. ***Maxillofacial/Cranial Surgery (21120-21256).*** These services will be covered only to restore physical function. This type of surgery for cosmetic purposes will not be covered.
5. ***Rhinoplasty and Septorhinoplasty (30460-30465).*** These are surgeries to reshape the nose and repair the septum. These services will be authorized when they are for other than cosmetic and snoring purposes.
6. ***Temporomandibular Joint Surgery (TMJ)(29800-29804).*** Medicaid will reimburse for TMJ surgical services only after there is documentation that prescribed conservative treatment failed to improve the condition.
7. ***Positron Emission Topography (PET) Scans.*** This diagnostic imaging procedure will be covered when there is an appropriate diagnosis such as cancer, heart condition, or epilepsy (each PET scan is used to diagnose individual condition).

For prior authorization details, see the *Physician Related Services* manual replacement pages dated June, 2003. Manuals, notices, replacement pages, and fee schedules are available on the Provider Information website.

## **Contact Information**

To inquire about prior authorization, please contact:

Surveillance/Utilization Review  
P.O. Box 202953  
Helena, MT 59620-2953  
Phone- 406-444-0190 or 406-444-1441  
Fax- 406-444-0778

For more information, visit the Provider Information website:

**<http://www.mtmedicaid.org>**

For claims questions or additional information, contact Provider Relations:

**Provider Relations in Helena and out-of-state: (406) 442-1837**

**In-state toll-free: 1-800-624-3958**